

# Pediatrics & Parents

*The newsletter for people who care for children*

Richard J. Sagall, MD, Editor

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## Treating Ear Infections

The firstline treatment for children with otitis media with effusion (a middle ear infection with fluid behind the ear drum) is antibiotics. Many children with this condition are also treated with antihistamines, to decrease swelling of the eustachian tube, and decongestants to “loosen up” the fluid in the middle ear behind the ear drum. A recent review of the medical literature found no support for the use of these two drugs. Eleven percent of the children using antihistamines and/or decongestants experienced side effects such as stomach upset and drowsiness.

“Because we found no benefit for any of the studied interventions [using antihistamines or decongestants] for any of the outcomes measured and we found harm from the side effects of the interventions, we recommend that practitioners not use antihistamines, decongestants, or antihistamine/decongestant combinations to treat otitis media with effusion in children,” said Dr. Glenn Griffin, the lead researcher. The American Academy of Family Physicians, the American Academy of Pediatrics and the American Academy of Otolaryngology-Head and Neck Surgery have all made the same recommendation.

The use of these drugs had no effect on being cured within one month, lessening hearing loss, risk of recurrence of otitis media with effusion, development of otitis media without effusion, and the need for tympanostomy tubes (ear tubes).

Sometimes less is best. That’s the situation with using antihistamines and decongestants in treating otitis media with effusion.

*Pediatric News*, 11/06

## Healthy Food in Schools

In many states schools are limiting unhealthy classroom treats because of concerns of obesity. For example, some California schools now limit cupcakes and other treats to only three times a year. Other districts have completely banned celebratory snacks.

The Texas legislature is a little more soft-hearted. It passed the “Safe Cupcake” amendment that allows parents to bring to their children’s classes non-nutritious snacks on special occasions such as birthdays, Valentine’s Day, and Halloween.

Experts warn that moderation rather than elimination is the key to success. They believe the more non-nutritious sugary treats are restricted, the more desirable they are to children.

*American Family Physician*, 12/15/06

# Childhood Obsessive-Compulsive Disorder: Guide to Effective Treatment

*By Eric A. Storch, PhD*

As adults, we recall our childhood days of avoiding stepping on cracks or repeatedly asking our parents “if we are there yet.” Repetitive play, superstitions, and ritualistic games are normal parts of childhood. Yet some parents are faced with the issue of their child’s ritualistic behaviors becoming a problem.”

Obsessive-compulsive disorder (OCD) is characterized by intrusive, troubling thoughts (obsessions), and repetitive, ritualistic behaviors. Repetitive and ritualistic behavior is aimed at reducing anxiety typically brought on by unwanted, intrusive thoughts. Individuals with OCD experience time-consuming obsessions and compulsions (although some children only experience one) that significantly impair functioning and/or cause distress. OCD occurs about equally in boys and girls and begins in childhood 80% of the time. Without treatment, OCD persists into adulthood and is associated with long-term negative outcomes such as reduced social functioning.

## **Symptoms**

OCD is often difficult to detect because many physicians are unfamiliar with the symptoms, other disorders that may “mask” OCD (e.g., disruptive behavior), and the embarrassment many youth may experience related to symptoms. Common obsessions include fears of harm, contamination, religious fears, or need for symmetry. Common compulsions include repetitive washing/cleaning, repetition of routines, reassurance seeking, and ordering/arranging. Consultation with a clinical psychologist or psychiatrist will help determine if your child has OCD.

## **Treatments**

Fortunately, there are two treatments available with strong support: cognitive-behavioral therapy (CBT) and pharmacotherapy with serotonin reuptake inhibitors (SRIs).

## **Cognitive-Behavioral Therapy**

Cognitive-behavioral therapy for OCD is distinguished from other “talk-therapies” and incorporates a structured approach to teaching the family skills in responding to symptoms. Whereas play-based, supportive, and psychoanalytic therapies have not been demonstrated effective for OCD treatment, the efficacy of CBT has been well supported in numerous trials with excellent maintenance at follow-up. In fact, studies have shown

that when compared to medication alone, CBT tends to have greater effectiveness than medication alone.

Cognitive-behavioral therapy for pediatric OCD is based on the notion that compulsions are performed to reduce or avoid anxiety associated with obsessions. The approach consists of three interrelated core components: 1) exposure (placing the child in situations that elicit anxiety related to his obsessions); 2) response-prevention (detering the ritualistic or compulsive behaviors that may serve to reduce anxiety); and 3) teaching objective thinking strategies (e.g., training the child to identify and correct anxiety-provoking cognitions).

Exposure relies on the gradual reduction of anxiety after being exposed to a feared or ritual-provoking stimulus. Successive exposures with the feared stimulus result in both decreased elevations in anxiety and more rapid reduction of distress in future exposures.

Response-prevention is based on the assumption that rituals/compulsions serve as short-term anxiety reducers via negative reinforcement (escape and/or avoidance of distress). As individuals with OCD perform rituals to reduce anxiety, they do not have the experience of having anxiety reduced without doing rituals. Accordingly, response-prevention requires the individual to avoid engaging in the ritual so that anxiety can be reduced via habituation instead of by rituals.

Finally, children who are old enough are taught cognitive responses to anxiety, which are based on the notion that anxious thoughts involve inaccurate conclusions or interpretations of events. Children with OCD often think bad things will happen to them and that such things are likely and their fault. Cognitive techniques provide the child with objective ways to “talk back” to anxiety-provoking obsessions in an attempt to reframe such thoughts in a realistic manner.

When first starting therapy, the child and therapist develop a “fear ladder” that consists of a hierarchical listing of situations that provoke rituals. In subsequent sessions, the therapist and child (often with parental assistance) progress up the ladder by systematically exposing the child to events that provoke rituals while having the youth refrain from ritual engagement. Family involvement is central to the success of therapy as family members may accommodate the child’s symptoms by facilitating avoidance, assisting with ritualistic

behaviors, or inadvertently participating in rituals (e.g., providing reassurance, allowing compulsive avoidance of feared stimuli, tolerating delays associated with ritual completion).

**Pharmacotherapy**

The biological theory of OCD hypothesizes that abnormal serotonin metabolism causes the symptoms. Well-designed trials of selective serotonin reuptake inhibitors (SSRIs) such as clomipramine, sertraline, fluoxetine, paroxetine, or fluvoxamine have demonstrated clinically significant reductions in OCD symptoms in children and adolescents. The choice of which first-tier psychotropic drug to use should be based on the patient's medical history, other medications being taken, and the possible side effects.

Parents and children must remember that a response is unlikely within the first several weeks of treatment with an SSRI. Generally, 10-12 weeks at an adequate dosage is necessary to evaluate a medication's effectiveness. Also, a poor response to one SSRI doesn't mean another one won't work. This means the doctor may have to try a number of different SSRIs before finding one that works.

In general, the SSRIs are well tolerated by most people with OCD and have similar side effects which include nervousness, insomnia, restlessness, nausea, and diarrhea. The most common side effects of clomipramine are dry mouth, sedation, dizziness, and weight gain. Although these medications can cause sexual problems in adolescents, on average these are a bit more common with clomipramine. Clomipramine is also more likely to cause problems with blood pressure and irregular heart beats, so that children and adolescents with preexisting heart disease who are treated with clomipramine must have electrocardiograms before beginning treatment and at regular intervals thereafter.

**Concerns and Future Directions**

Unfortunately, numerous barriers remain that limit availability of effective OCD treatments. The lack of professionals trained in CBT has been identified as a great barrier to successful treatment. Limited access to specialists familiar with CBT may result in the prescription of pharmacotherapy alone and/or other psychotherapies that have not been demonstrated as effective.

**Parent and Practitioner Tips**

One goal of this article is to spread the word about effective treatment of pediatric OCD. Unfortunately, it is not often easy to connect patients to appropriate therapeutic and informational resources. Given this, the following are several tips that may be useful:

- Pediatric OCD, although relatively common, is not seen that often by most doctors who care for children. The primary role of the child's doctor is to assist with case identification and subsequent referral to a child psychiatrist or psychologist.
- Psychologists, psychiatrists, and mental health professionals believe in a variety of treatment approaches. Some, for example, closely follow a cognitive-behavioral approach such as the one described here. Others, in contrast, may use different approaches that have not been shown to be successful. It's important to find a psychologist trained in CBT for OCD.
- If a practitioner cannot be located within your vicinity, a number of university-based programs offer intensive outpatient or residential treatment programs (see [www.ufocd.org](http://www.ufocd.org) for an example). These programs allow families to temporarily relocate for several weeks to receive cognitive-behavioral and pharmacological treatment.
- The Internet can be an excellent source of information for families. Two particularly useful resources for general information and locating treatment providers include the Obsessive-Compulsive Foundation ([www.ocfoundation.org](http://www.ocfoundation.org)) and Anxiety Disorders Association of American ([www.adaa.org](http://www.adaa.org)).

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**Stress in Children**

A survey of 875 children nine to thirteen years old revealed their top ten causes of stress.

Grades/school/homework .....	36%
Family .....	32%
Friends/teasing/gossip .....	21%
Siblings .....	20%
Mean/annoying people .....	20%
Parents .....	14%
Yelling/loud noise .....	9%
Fighting.....	9%
Sports.....	8%
Lack of autonomy .....	7%

*KidsHealth KidsPoll, 2006*

# Developing Childhood Event Memory

*By Emily Brandon*

An adult is most likely to remember an event when it is exciting or out of the ordinary, but this may not be the case for your toddler. Until age two and a half your child is still developing the ability to form memories. Everything is new to two year olds, according to Dr. Robyn Fivush, Professor of Psychology at Emory University. Two year olds are still in the process of learning about their surroundings. Your child has to figure out what usually happens before he can pick out novel events. Kids tend to remember things that follow along with their daily routine, such as snack time or play time. In fact, when asked about a special event such as a camping trip or plane ride, children are most apt to remember routine information such as breakfast or dinner, according to Fivush. This memory for routine events helps children to predict what is going to happen and makes them less anxious and better able to take part in familiar events. So, developing a routine with your child, such as reading together or bedtime preparation, can provide the basis for recognizing and remembering important novel events later in life, according to Fivush.

"Routines certainly do promote memory development," agrees Dr. John W. Hagen, Ph.D., Professor of Psychology at the University of Michigan and Executive Officer of the Society for Research in Child Development. "Almost all children have many routines in their lives and they seem to thrive on them." There are a variety of other simple ways to promote memory development. The easiest is to "Talk, talk talk!" says Fivush. Parents who talk a great deal about the past have children who recall their own past more coherently. It is important to include lots of details including where and when the event occurred, who was there, what happened, and how everyone felt about it. In fact, studies have shown that when a mother and child engage in an event together, the child best remembers the specific aspects of the event that the mother and child talked about as the event unfolded. Events that are talked about both as they are occurring and in retrospect are recalled even better, especially if the event is talked about in elaborated and detailed ways.

You can also ask your children open-ended questions that force them to provide information on their own, rather than asking 'yes' or 'no' questions, Fivush suggests. She also says that open-ended questions ask the child to provide information that he retrieves from his own memories, rather than simply confirm or deny

that something happened. Free response questions can also help children to develop coherent memories of their past, which are related to both social skills like self-esteem as well as cognitive skills like literacy and reading skills.

Interactions between children and adults play a crucial role in the development of event memory. Adult-child conversations about past events can influence what children come to retrieve and report about their memories. Parent-child discussions also serve to focus children's attention on salient aspects of an event and increase their understanding of it. Talking with your child while an event is occurring and then helping him to recall the event later can result in a richly detailed memory of the experience. For example, a mother may facilitate her child's comprehension of an event by naming component features of the experience and focusing attention on particular aspects of the event that are especially important. If this naming is followed by the child's verbal elaboration, a more enriched representation of the event may be established.

Dr. Catherine A. Haden, Associate Professor of Developmental Psychology at Loyola University in Chicago, has developed a procedure to train mothers in the use of four conversational techniques to enhance their children's understanding of unfolding events and subsequent remembering.

1. Wh- questions that ask the child to provide information, such as when, where, why, what, who, or how (e.g., "Why would a workman wear that kind of hat?").
2. Associations that involve making connections between what is happening in the here-and-now of the event and what a child might already know or have experience with (e.g., child picks up a stethoscope and the mother asks, "Has anyone ever used one of these on you?").
3. Follow-ins that encourage discussion of aspects of an event about which the child shows interest (e.g., child says, "Look what I found," and mother responds, "There you go. What's that called? Do you know?").
4. Positive Evaluations that praise the child's verbal and nonverbal behaviors (e.g., "Good job hammering.").

Children of mothers who displayed these conversation techniques recalled more elaborative information in re-



sponse to open-ended questions posed by an examiner such as, "What do you remember about the camping trip?". Thus, elaborative conversations about past events may enhance recall, Haden says.

Even young children are able to recall information over long periods of time. However, they are much more reliant on external cues and prompts in order to access that information than older children and adults, according to Haden. Younger children will also provide less information in response to any given prompt, unless adults provide cues that aid recall. "We have observed that mothers who are highly elaborative in talking about the past facilitate their children's developing abilities to report on past experiences in a detailed manner," Haden says. "Moreover, we have recently shown that adult-child discussions about novel events as they unfold also affect children's acquisition of skills for remembering." Social and communicative

interactions between children and adults play a crucial role in the development of event memory. Hagen agrees that almost all activities that are positive and contain language and activity will promote learning and hence memory.

Most adults report having few, if any, memories from the first three years of life. The question of why early childhood memories rarely survive into adulthood has long fascinated psychologists. Fivush speculates that many factors are involved, including language skills, narrative skills, and the way in which parents talk with their young children about past events. Haden speculates that children will show enhanced event memory when they have engaged with their mothers in elaborative discussion of the events.

*Emily Brandon is currently a freelance writer in Winter Park, CO. She has also conducted child development research at the University of Rochester in Rochester, NY.*

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## Is My Baby Tongue-Tied?

*By Christine Bradley*

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Tongue-tie, or ankyloglossia, refers to a tongue that is attached too tightly to the floor of the mouth due to a short or tight frenulum (the thin membrane that attaches the tongue to the floor of the mouth). Tongue-tie is estimated to occur in about 5% of newborns. Your baby's pediatrician can check for a short frenulum during a newborn assessment.

There are several potential problems associated with having a short or tight frenulum. One of the most immediate problems that you may notice if your baby is tongue-tied is trouble latching on to the breast. Often this is the first clue that your baby may be tongue-tied. Because the baby is unable to extend his tongue past his gums and curl his tongue under the nipple, latch-on may be very painful for the mother. Also, poor latch-on may lead to inefficient removal of milk from the breast and baby may not get enough to eat.

Another potential problem with tongue-tie is impaired speech development. While most babies with tongue-tie go on to talk normally, others may have difficulty articulating certain sounds, especially talking fast. Also, a child with tongue-tie may be at an increased risk for dental problems because he cannot use his tongue to clear away food from his teeth and spread saliva as efficiently.

If your baby is tongue-tied there are some good treatment options. One option is to leave the frenulum alone and let it loosen and stretch over time. While

most tongues naturally loosen, you may want more immediate results, especially if you are having trouble breastfeeding your baby. Many pediatricians will clip a frenulum that is too tight. This quick and relatively painless office procedure is called a frenotomy and can be performed either with a local anesthetic or without one. An infant's frenulum is very thin and usually there is very little if any bleeding. Most mothers report that their sore nipples are alleviated immediately after the procedure and that their babies are able to nurse very well.

If you and your pediatrician decide that your baby's frenulum is not tight enough to warrant clipping, pay attention to your child's speech development over the years. As I've mentioned earlier, most tongues do loosen on their own, but if your child still has difficulty extending his tongue when he is older, you may want to see a speech pathologist. A speech pathologist can help your child with exercises to stretch the tongue and improve oral development. Parents can also encourage regular tooth brushing and flossing and limit sweets to help improve oral health.

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# Children in Hospitals

*By John E. Monaco, MD*

## A Girl with Belly Pain

It is well known amongst those who care for children, that one of the more vexing diagnostic challenges is the child, particularly the little girl, with belly pain. There is no research to support the observation that girls are more challenging... this is a purely anecdotal observation!

If the complaint is clear-cut, the diagnosis is easier. For example, if the child has fever, sudden onset of right lower abdominal pain along with nausea and vomiting, there is a good chance this complaint might be due to appendicitis. If the pain is in the upper abdomen, not associated with fever and either improves or worsens with eating, the pain could indicate gastritis or possible reflux disease. If it is associated with vomiting, fever and diarrhea, pain could be due to an intestinal infection. If the diarrhea is bloody, a more severe infection, like *E. coli* might be considered. However, understand that all the above diagnostic scenarios have exceptions. In other words, appendicitis could present with any of the symptoms listed above, and acute gastroenteritis may present without diarrhea.

The key to an accurate diagnosis is a good history, because even the physical exam may sometimes fool the doctor. For example, there's been more than one child whose appendix was removed only to find out later that he actually suffered from lower lobe pneumonia. What is the reason for this seemingly glaring error? The pain can feel exactly the same in both situations.

Recently I cared for a seven-year-old girl who came to the emergency room with abdominal pain. She described it as central ("around my belly button" were her words). It was not associated with diarrhea. There had been fever the day before, and every time she tried to drink something, she vomited. She did not appear terribly distressed, but she did not hesitate to tell me, each time I went to check on her, that her stomach hurt. In the emergency room, when she was admitted, a CT scan was done to rule out appendicitis. Nearly every child with a suspicion of appendicitis these days gets a CT scan. Most scans, it turns out, are negative. But for children who are difficult to diagnosis, this technology has been a godsend, and undoubtedly saved lives,

and prevented many complications due to more timely surgery. This young lady's CT scan was negative for appendicitis.

Her diagnosis was confirmed by her lab work. It was noted early in the course of her work-up that her pancreatic enzymes, amylase and lipase, were markedly elevated. From this we were able to conclude that she was suffering from pancreatitis. There are multiple causes for this disorder. It can be as a result of trauma. A common scenario is a child falling off her bike, with handlebars hitting the mid/upper abdomen. In this case the pancreas becomes inflamed directly as a result of the impact. Pancreatitis can also be caused by certain drugs or viral infections. Almost one quarter of the time the cause is unknown.

Since our little patient had experienced fever, and her lab work pointed to an infectious etiology, we concluded, along with help from our gastroenterologist, that her pancreatitis was most likely caused by a viral infection. This meant, of course, that there wasn't anything specific we could treat. We would have to let the viral infection "run its course" as we like to say. Since there is no specific treatment for pancreatitis anyway, other than bowel rest, IV hydration and pain medications, it sometimes appears to families that we aren't doing anything other than watching and waiting. In actuality, this is true!

The "bowel rest" aspect of the treatment regimen can be very frustrating for both the patient and her parents. Bowel rest means that the child must not be fed or given anything to drink. It always interests me how many times parents "cheat" when given the order that their child must not eat or drink anything until further notice. It is counterintuitive, and against all parental instinct, to deny their child food and fluids when she is sick... or anytime for that matter. In pancreatitis, however, when children take so much as a sip of water, they can almost immediately begin to vomit and complain of severe pain. So it is very difficult to cheat without getting caught.

Our little patient got better, with time, but it took several days. And each morning, during rounds, I would

ask her if her belly hurt, and up until the last day, she said “yes,” knowing this would mean, once again, that she wouldn’t be allowed to eat. On the final day, however, she smiled when I walked into her room, as if she had anticipated my question. And when I asked what had become my routine morning question, she gave a resounding “no” and then asked, “Can I eat today?” After palpating her belly and realizing that indeed it was pain-free, it was with great pleasure and relief that I answered her question in the affirmative.

*John E. Monaco, M.D., is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.*

## Sleuthing Out Precocious Puberty

It’s a reason for concern when the changes of puberty occur before age seven in girls or age nine for boys. This condition, called “precocious puberty,” may indicate an endocrine or other disorder. But there are some less serious causes of precocious puberty. Exposure to certain hormones, such as testosterone, is one.

In April 2006, Dr. Michael Dedekian and his colleagues from the University of Massachusetts Medical School presented a paper at the Pediatric Academic Society that discussed the case of two siblings, a 3-year-old girl and her 5-year-old brother, who began to grow pubic hair. Their doctor was concerned about a genetic endocrine disorder since it’s rare for two siblings to show the signs of precocious puberty. What was particularly odd was that the changes occurred in both children at the same time.

Further investigation revealed that their father had ordered a concentrated testosterone skin cream over the Internet for cosmetic and sexual performance purposes. Normal skin contact between the children and their father resulted in enough absorption of the testosterone by the children to cause their pubic hair growth and genital enlargement. The boy also became more aggressive. Once the children’s exposure to all family members who had used the cream was eliminated, their prepubertal and behavioral problems returned to normal.

*New York Times, 10/17/06*

Check out the  
*Pediatrics for Parents* podcast

## Degrading Song Lyrics & Teen Sexual Activity

Can listening to degrading song lyrics encourage a teenager to have sexual intercourse earlier than if he didn’t listen to such music? Teens may argue that their playing violent video games or listening to profane music doesn’t necessarily make them more violent or obscenity-prone, but the results of a RAND Corporation study support the hypothesis that listening to degrading music can, and does, encourage earlier sexual activity among teens.

In the study released in August 2006, Stephen C. Martino, PhD, and his colleagues from RAND Corporation and UCLA, specifically wanted to know if and how the content of music lyrics influenced sexual activity/experience and intercourse initiation. The study consisted of initial telephone interviews of 1461 teenagers age 12-17, then telephone interviews with them one year then three years later (1242 of the teenagers followed through with all three phone interviews and their results were used for the study). At each time point, the teens were asked about their sexual experience and twelve other factors that are known to be associated with sexual activity initiation. A subset of 938 of the teens was identified as virgins, to serve as a baseline before music exposure. The teens were also asked about their music preferences and how often they listen to music. The lyrics with sexual content were analyzed and categorized as “degrading” or “nondegrading.”

The results of the study indicate that indeed, those teenagers who listened to “degrading” song lyrics were more likely to engage in sexual activity and earlier intercourse. The researchers found that listening to “nondegrading” lyrics did not affect the teenagers’ sexual behavior.

While the researchers encourage reducing degrading song lyrics in the music industry and reducing teenagers’ exposure to such music, critics of the study point out that the study merely shows a correlation (relationship), not a causal effect (that listening to degrading lyrics directly causes teens to engage in more sexual activity). They argue that the teens chose their own music, and those who would tend to listen to degrading song lyrics most likely would engage in earlier sexual activity. Had the researchers randomly assigned music to teenagers then measured their sexual behavior one and three years later, the results would be more reliable.

*Pediatrics, 08/06*





# Perspectives on Parenting

*By Michael K. Meyerhoff, EdD*

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## Delayed Gratification

As we put another Christmas season into the past, I once again find myself feeling deeply dismayed about the now annual phenomenon of the “must have” toy. From the Cabbage Patch dolls of two decades ago to the Tickle Me Elmo of today, it seems that we can’t get through the month of December without watching multitudes of mothers and fathers expending huge amounts of time, energy, and money in a desperate attempt to obtain some highly popular yet agonizingly scarce item for their little ones.

Some of the stories are really scary. I don’t know if it’s true, but I heard about a local television station in Wisconsin that told its audience a plane full of precious dolls would be flying over Green Bay at 5:00 AM on a Sunday morning and would be dropping some of its cargo into the parking lot of the stadium where the Packers play their home football games. Those who wanted the dolls were instructed to be present at the appointed time and to hold their credit cards in the air so customer service people in the plane could take aerial photographs and bill them later. Reportedly, more than 300 mothers and fathers stood in below zero weather at the crack of dawn holding high their pieces of plastic.

I do know for a fact that a local radio station in Chicago conducted a giveaway in which listeners could call in for a chance to choose between a dollar or a thousand dollars. I don’t know the exact numbers, but I heard that despite the fact that the retail price of the doll is less than fifty bucks, many of the callers who got through opted for the doll instead of the dollars, claiming that they would have to pay more than that on various Internet auction sites.

As ludicrous and potentially erroneous as these stories may be, they are not hard to believe. That the phenomenon of the “must have” toy has become an accepted part of our culture is extremely disturbing. Parents who participate in such nonsense may have convinced themselves that they are ensuring the their children’s happiness, but the reality is that they are seriously damaging the mental health of the next generation.

Sigmund Freud himself would be the first to point this out. While his rather bizarre psychosexual theory of development has generally fallen into disfavor, his descriptions and explanations of the three components of personality remain well respected a century after they were first introduced. According to Freud, as we go through life, our actions are governed by the interaction of our Id, Ego, and Superego. The Id represents our desires, the Superego represents the requirements and expectations of society, and the Ego represents the rational decision maker. You can think of the Id as the devil on one shoulder, the Superego as the angel on the other shoulder, and the Ego as the guy stuck in the middle.

Despite the way the term is used in the common vernacular, a strong Ego is not a bad thing. It doesn’t mean one has a swelled head. Instead, it indicates that an individual is able to maintain a proper and healthy behavioral balance. If the Id is in control, then you have a self-centered jerk who will trample on the rights of others to get whatever he wants. If the Superego is in control, then you have a timid nerd who is afraid to have any fun. However, if the Ego is in charge, then you have an individual who can enjoy life in a sensible and responsible manner. In other words, you have an Ego that can figure out how to satisfy the Id without upsetting the Superego.

It is critically important to understand that the job of the Ego is not to deny the Id. The Superego may want to crush the Id with an overly strict conscience, so the Ego has to ensure that the Id does get what it wants. But it also is critically important to understand that although the Ego is the Id’s protector, it is not the Id’s partner. The Id may determine what is wanted, but the Ego determines how and when it will be obtained, and that decision is made with all due respect to the Superego. And the bottom line is that the Ego typically has to tell the Id, “I’ll get you what you want, but you’ll have to wait a while.”

Freud formalized this in two principles. He talks about the Pleasure Principle, which is defined as the Id’s boundless drive for immediate gratification. The Id



wants what it wants when it wants it. The Ego operates on the Reality Principle, which is defined as the capacity to delay gratification. And it is not a coincidence that he pairs “delayed gratification” with “reality.” In the real world, you can’t always get what you want when you want it, and if you’re going to enjoy good mental health, you’re going to have to learn to deal with that.

Children possess a fully formed Id from birth, but it is up to their parents to help them develop an Ego and Superego. Unfortunately, many modern parents feel it is their job to simply feed their children’s Id. Instead of telling their kids that an item is unavailable or too expensive, they seem compelled to instantly satisfy their children’s desires at any cost. As a result, the children grow up with a severely distorted idea of what is possible and appropriate.

As noted earlier, the phenomenon of the “must have” toy began about two decades ago with the Cabbage Patch dolls. And the consequences have become increasingly clear. Psychologists routinely perform a simple test with children as young as three or four years old. They tell the children they can have one piece of candy right now, or they can have five pieces of candy if they are willing to wait a few minutes. It used to be that most children waited patiently for the bigger payoff. In recent years, an increasing percentage of kids are grabbing for the single goody.

More alarming is what’s going on with the Cabbage Patch generation now that they are young adults in their mid-twenties. They have everything they could possibly want, from loaded-with-special-features cell phones to late model sports cars to elaborately furnished apartments with big-screen high-definition televisions. They also are setting records for credit card debt and bankruptcy filings. And while these young adults may have higher degrees from top-notch universities, many of them are not being hired because employers have sensed feelings of entitlement. These young folks want the high-paying supervisory positions right away and are offended when they are told they have to spend a certain amount of time “learning the ropes” and “paying their dues.”

I have personally witnessed some of these over-indulged 25 or 26 year olds experience personal disaster. As their precious cars are being repossessed, a store clerk informs them their plastic card has reached its limit, or an employer tells them they are not getting the job, they stand there with a look of disbelief, steadfastly insist there must be some mistake, and then adamantly demand more time, more credit, or more consideration. What is really sad is the puzzled look on their face when they receive the reply of a laugh and the sneering admonition to “get real.”

I am sure that there will be another “must have” toy next Christmas. But I hope that more parents will come to their senses and elect not to participate in the phenomenon. As a parent, it is more important to focus on what your children need instead of what they want. It is difficult to see your children suffer disappointment, and it is hard to hear them complain that they are the only ones without a Tickle Me Elmo, X-Box, Blackberry, or the list goes on. But no one ever said being a good parent is easy. And, believe me, whatever temporary discomfort you feel when you say “no” or “not now” will be far outweighed by the ever-lasting pride and joy you will experience when you see your children develop into sensible, responsible adults – and possibly the only ones among their peers who possess a strong, healthy Ego.

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## Dogs Worsen Asthma

Dogs may be man’s best friend, but they are not the best friend of children with asthma. A study of 3,227 children, 475 of whom had asthma, found that households with dogs had more indoor air pollution than households with no pets or with cats as the only pet. Households with both dogs and cats had the highest indoor air pollution levels than those that are “dog-only.” The higher the level of indoor air pollution, the more symptoms shown by the asthmatic children.

Analysis of the air found significantly more nitrous oxide, ozone, inorganic acid, organic acid, and particulate matter of all sizes in the air of homes with dogs than in dogless homes. Factors such as the community’s level of air pollution, sex of the child or the animals, ethnicity, socioeconomic status, tobacco use in the household, mildew, water damage, parental asthma, and cockroaches in the house didn’t affect the results.

Should Fido be shown the door if your child has asthma? That depends on many factors, including the severity of your child’s asthma, how well it’s controlled, and how important a family member Fido is.

*Environmental Health Perspectives, 11/06*

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# Hoarseness in Children: What Every Parent Should Know

*By Yolanda D. Heman-Ackah, MD, Steven Mandel, MD,  
Karen M. Lyons, MD, and Robert T. Sataloff, MD, DMA*

## **How is the Voice Produced?**

To understand what causes hoarseness, it is first necessary to understand how the voice is normally produced. The larynx is the primary organ involved in voice production. However, speaking, crying, singing, or the production of any vocal noise involves a complex interaction between many bodily systems.

## **Laryngeal Anatomy**

The larynx is often referred to as the “voice box” because it is the primary source of sound in humans. It is what is commonly referred to as the “Adam’s apple” in the neck. It sits at the back of the tongue and in front of the esophagus, which is the swallowing tube that leads to the stomach. The larynx is the opening to the windpipe, which carries air to the trachea and lungs (Figures 1 and 2). In humans, the larynx has four main functions: to protect the lungs from foreign materials such as food and liquid, to direct air into the lungs during breathing, to produce the voice, and to help in stabilizing the pressure within the chest during activities such as lifting and straining. The larynx is composed of cartilages, muscles, nerves, and the vocal folds.

The vocal folds come together and meet in the midline to close the larynx. The laryngeal muscles help to bring the vocal folds together during swallowing and prevent the passage of food particles and liquids into the trachea. The laryngeal muscles also contract to bring the vocal folds together in voice production. When air is pushed from the lungs past the closed vocal folds, a sound is made. This sound is the voice. If the vocal folds are able to make good contact and vibrate normally, a clear sound is made. The pitch of the voice is raised when the vocal folds stretch, and it is lowered when they relax and become shorter. The vocal folds open to allow air into the lungs during breathing and to permit breaks between sounds during speech.

There are two nerves on each side of the body that send messages back and forth between the brain and the larynx. These nerves send information to the brain from the larynx about different sensations in the larynx and trachea. They also send messages from the brain to the larynx to direct movement of the vocal folds during talking, breathing, swallowing, and lifting.

Both nerves are like telephone lines and have a long route of travel through the head, neck, and chest as they convey messages back and forth between the voice box and the brain. Because of this long route, there exists a large potential for injury from a variety of surgical procedures. The nerves are most commonly injured during thyroid, neck, heart, lung, chest, carotid, and cervical spine surgical procedures, but can be injured by any surgery that is performed near the nerve in the head, neck, or chest. When the nerve is partially injured, paresis or weakness of the vocal fold results. If the nerve is completely injured, then paralysis or immobility of the vocal fold results.

## **Sound Production**

The sound source for voice production is the larynx and the vibrating vocal folds. When one makes the decision to talk, the vocal folds come together in the midline. Air is forced from the lungs past the closed vocal folds and they begin to vibrate. A louder sound can be produced by one of two methods: by increasing the airflow from the lungs or by increasing the force of closure of the vocal folds. Oftentimes, increasing the pressure in the vocal folds causes strain in the vocal folds and the muscles in the neck, throat, tongue, and jaw. Such strain is termed laryngeal hyperfunction, and the forceful closure of the vocal folds can cause vocal fold trauma and result in vocal fold tears, hemorrhages, edema (swelling), or masses such as nodules, polyps or cysts.

## **Resonance and Amplification**

The resonance chamber and amplifier of the voice is the vocal tract, which includes the back of the throat (pharynx), the tongue, the palate, the mouth, the back of the nose (nasopharynx), the sinuses, and the head. As sound leaves the vocal folds, it becomes louder as it interacts with the tissues in the head and neck. A different shape of the vocal tract, such as can occur with large tonsils, large adenoids, or a cleft (or separation) of the palate or lip affects the quality of the voice as well as the ability to project the voice.

## **What is Hoarseness?**

Hoarseness is the sound produced when something inhibits the vocal folds from vibrating normally. This can be caused from incomplete closure of the vocal folds, which can occur with vocal fold paralysis or pa-

resis. Vocal fold masses such as nodules, polyps, cysts, papilloma, and edema (swelling) can also cause hoarseness. Vocal fold nodules are callous-like masses; cysts are blister-like masses; and polyps are jelly-like masses that form on the vocal folds as a result of chronic over-use, loud crying, yelling, screaming, or excessively loud talking. Papillomas are warty growths that can grow on the vocal folds as a result of infection of the airway with the human papilloma virus. Infection with the human papilloma virus usually occurs during birth or infancy, but the warty growths and corresponding hoarseness may not begin until early childhood or adolescence. In some cases, papillomas are first noted in adulthood. Trauma to the neck can cause fractures of the voice box and paresis or paralysis of the nerves.

### **When Should Hoarseness be Evaluated?**

Any child who experiences sudden hoarseness or difficulty breathing or swallowing from trauma to the neck should be evaluated immediately. Any child who has hoarseness or vocal difficulties that persists longer than four weeks should have his larynx evaluated by a laryngologist or otolaryngologist. It is rare for a "laryngitis" alone to persist for more than two weeks, even if the hoarseness began during an upper respiratory tract infection. In such instances, the persistent hoarseness may be due to a mild paresis of the vocal folds, and this should be evaluated. Alternatively, other disorders in the larynx, including warty growths caused by the human papilloma virus (usually called papillomas) and/or childhood cancers such as lymphoma or sarcoma, may begin with hoarseness and should be evaluated. If left untreated, these lesions may grow large enough to block the airway, limit breathing, and potentially cause death.

### **Conclusion**

The voice is produced by the larynx and involves the use of the head, neck, chest, abdomen, and back. There are two instances in which the larynx definitely should be evaluated. The first is when hoarseness is abrupt in onset and not associated with an upper respiratory tract infection, and the second is when hoarseness persists for longer than four weeks, even if the onset was during the course of an upper respiratory tract infection, such as the common "cold."

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## **Hearing Loss from MP3 Players**

Many users of MP3 players and other personal music devices have never seen the hearing warnings on the packaging. According to the Royal National Institute for Deaf People (RNID), "58% of 16-30 year olds are completely unaware of any risk to their hearing from using MP3 players and other audio products that attach directly to the ears."

Another finding from their study is that 79% of 16-30 year olds have never read the warning on the MP3 players' outside packaging. The RNID believes "that MP3 manufacturers have a responsibility to their customers to alert them to the potential dangers of listening to their products at high volumes."

According to Dr. John Low, chief executive of the RNID, "We know that young people are at risk from losing their hearing prematurely by listening to loud music for too long on MP3 players. MP3 player manufacturers have a responsibility to make their customers aware of the risks and the need to listen at sensible levels and we urge them to incorporate prominent warnings into the packaging of their products."

Angela King, senior audiologist at RNID, warns that, "Hearing loss from loud noise is caused by listening too loudly for too long a period. Ringing or buzzing in your ears after using an audio player is a warning sign that if you continue to stress your ears like this, you could damage your hearing permanently."

The RNID advises music fans to take some simple steps to protect their hearing whenever they listen to music:

- Turn it down a notch! Even a small decrease in volume could considerably lessen the damage to your ears.
- If another person can hear sounds from your headphones from two or three feet away, then the volume is too loud.
- Take a five-minute rest period every hour of listening for all ears to recover.
- Stand away from loud speakers when in pubs and clubs or at gigs and concerts.
- Take regular breaks from the dance floor in pubs and clubs and use chillout areas to give ears a rest from loud music.
- Wear earplugs specially designed for use in clubs and gigs, especially if you are regularly exposed to loud music, i.e. as a frequent clubber, gig goer, DJ, or musician.

*Royal National Institute for Deaf People, 09/06*



# Drug Use Declining

There's good news on the illicit drug use front – use is down among children and teens. The bad news is that drug use is up among young adults and those over age 50. The survey, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), compared drug use from 2004 to 2005 and used results from a self-reported drug use survey of 68,000 Americans.

For adolescents 12-17 years old:

- Marijuana use in the previous month declined from 6.1% to 6.0% – the fourth year the percentage decreased.
- Illegal prescription drug use fell from 3.6% to 3.3%.
- Past-month illegal use of inhalants use was stable at 1.2%.
- Past-month use of hallucinogens

was also stable at 0.8%.

- Cocaine use increased slightly from 0.5% to 0.6%.
- The number of first-time methamphetamine use declined by 40% from 318,00 to 192,000.
- The average age of first use of marijuana rose slightly from 17.1 to 17.4 years old.

*Pediatric News*, 10/06

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